FACILITY NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

LICENSURE TYPE: _____

LONG TERM CARE SEMI-ANNUAL REPORT
REPORTING PERIOD JULY 1, 2003 TO DEC. 31, 2003

STATE ID NUMBER: _____

HELP

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

In accordance with KAR 28-39-163 (d), this report shall be filed with the Licensure, Certification & Evaluation Commission (LCE), Ks.. Dept. on Aging by **Jan. 9, 2004**. Administrators/QMRPs shall indicate resident and employee data for the six month period - July 1, 2003 through December 31, 2003. Refer questions to Caryl Gill,, (785) 296-4222.

I. a) Was your facility in operation in the full six months of the reporting period (07/01/03 - 112/31/03)? ❒ YES ❒ NO
b) If answer was "NO," how many days was your facility in operation?_____ days

II. Licensed resident capacity at end of the reporting period: _____

III. Resident Information (include only 24 hour residents in Nos. 1 through 14). Complete all blanks. If nothing to report, enter zero.

	ICFMR
1. Inpatient days of care during the six month reporting period	_____
2. Admissions during the six month reporting period (include new admissions and re-admission)	_____
3. Discharges by hospitalization	_____
4. Discharges by death	_____
5. Discharges by transfer to a Community Based Program	_____
6. Discharges by transfer to State Institution	_____
7. Discharges by transfer to another ICFMR	_____
8. Other discharges (excluding 3, 4, 5, 6, 7)	_____
9. Total discharges during six month reporting period (sum of numbers 3 through 8)	_____
10. Resident census on last day of reporting period	_____

11. Resident census. Indicate 24 hour resident census for your facility on each day during the **week of NNovember 16-22, 2003.**
Sun _____ Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____
Note: Do not include day of discharge or days resident was hospitalized.

IV. Staffing Information. Complete all blanks. If nothing to report, enter zero.

12. Number of Direct Care Staff. Include employees on payroll and those hired through contract who provide direct care. Indicate below how many full-time and part-time staff were in the position listed during the **week of November 16-22, 2003.**

Direct Care Staff	ICFMR # Full-Time	ICFMR # Part-Time
Qualified Mental Retardation Professionals		
Professional Program Staff		
Registered Nurses (Exclude R.N. Consultants)		
Licensed Practical Nurses		
Licensed Mental Health Technicians		
Medication Aides		
Nurse Aides (Excludes CMAs LMHTs)		
Nurse Aide Trainees		

FACILITY NAME: _____ CITY, STATE, ZIP: _____

13. Number of Hours Worked Each Day (24 hours) by Staff in Selected Positions in the Intermediate Care Facility for the Mentally Retarded during the **week of Nov. 16-22 2003.** Indicate below hours actually worked by shift by all staff (full-time and part-time) for the positions listed below. Report number of hours worked in **whole numbers only**. If your facility uses two 12 hour shifts, report hours as though the facility uses three 8 hour shifts.

DAY SHIFT	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
1. Qualified Mental Retardation Professionals							
2. Professional Program Staff							
3. Registered Nurses (Exclude R.N. Consultants)							
4. Licensed Practical Nurses							
5. Licensed Mental Health Technicians							
6. Medication Aides							
7. Nurse Aides (Excludes CMAs LMHTs)							
8. Nurse Aide Trainees							

EVENING SHIFT	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
1 Qualified Mental Retardation Professionals							
2. Professional Program Staff							
3. Registered Nurses (Exclude R.N. Consultants)							
4. Licensed Practical Nurses							
5. Licensed Mental Health Technicians							
6. Medication Aides							
7. Nurse Aides (Excludes CMAs LMHTs)							
8. Licensed Social Worker							

NIGHT SHIFT	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
1. Qualified Mental Retardation Professionals							
2. Professional Program Staff							
3. Registered Nurses (Exclude R.N. Consultants)							
4. Licensed Practical Nurses							
5. Licensed Mental Health Technicians							
6. Medication Aides							
7. Nurse Aides (Excludes CMAs LMHTs)							
8. Licensed Social Worker							

I verify this information is correct and staffing information can be verified by payroll records.

Signature of Administrator/QRMP	**License No.**	**Date** (mm/dd/yyyy)	**E mail address**	**Phone Number**

RETURN TO LCE/KDOA, 1000 SW JACKSON, SUITE 330, CURTIS STATE OFFICE BUILDING, TOPEKA KS, 66612-1365

PRINT

BE SURE TO PROVIDE FACILITY NAME/ADDRESS ON PAGE 1

RESET